TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-17-0319-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have sent all proper documentation for their review, including the Certificate of Medical Necessity. On 08/30/2016 we sent our appeal for payment, and on 09/22/2016 the appeal was denied for all the same reasons."

Amount in Dispute: $99.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has not received any further preauthorization requests for a TENS unit rental, purchase, or otherwise. Nor has the requestor provided any evidence of such with its DWC60. For this reason Texas Mutual declined to issue payment for TENS supplies some eleven months after the expiration of the one month TENS trial rental of July 2015."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2016	A4595 -NU, A4630 -NU	$99.61	$12.83

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 891 – No additional payment after reconsideration

Issues

1. Did the carrier raise a new issue?
2. Are denial of payment reasons supported?
3. What is the rule that governs the reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for durable medical equipment provided on July 11, 2016 for $99.61.

   The carrier states in their position statement, "Texas Mutual has not received any further preauthorization requests for a TENS unit rental, purchase, or otherwise. Nor has the requestor provided any evidence of such with its DWC60. For this reason Texas Mutual declined to issue payment for TENS supplies…"

   Texas Administrative Code §133.307 (2) states,

   > Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:
   >
   > > (F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   Review of the submitted explanation of benefits finds insufficient evidence to support the Carrier presented the denial for the disputed services for "preauthorization" prior to the date the MFDR was filed. Therefore, the Carrier's position statement will not be considered in this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," 225 – "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information," and 892 – "Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions."

   28 Texas Administrative Code §134.203(b) states in pertinent part that,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The submitted codes are, A4595, NU – "Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)" and A4630, NU – "Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient."

Review of the applicable Medicare payment policy found at www.cgsmedicare.com, finds the following;

> *A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used).*
>
> *There should be no billing and there will be no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit.*

Based on the above, there can be no separate payment for code A4630.

The remaining code in dispute (A4595) was billed as two units, the above referenced Medicare policy states the following in regards to supplies.

> *Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is:*
>
> - *2 TENS leads - a maximum of one unit of A4595 per month*
> - *4 TENS leads - a maximum of two units of A4595 per month.*

Insufficient evidence was found to support a 4 Tens lead was being provided. Therefore, based on the above one unit will be reviewed per the applicable fee guideline found below.

3. 28 Texas Administrative Code 134.203 (d) states,

   The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   The fee for 2016 – Third quarter Texas DMEPOS Fee Schedule, www.cgsmedicare.com, is listed as $10.26.

   Therefore the maximum allowable reimbursement is $10.26 a 125% = $12.83.

   This amount is recommended.

4. Based on the above Division rules and fee guidelines payment is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $12.83.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $12.83, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 3, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.